	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BLDG: _	(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
	390326			B. WING: 04/18/2023				
	VIDER OR SUPPLIER: S ANDERSON AMBULAT	ORY SURGERY	STREET ADDRESS, 2200 ST. LUK EASTON, PA	E'S BLVD	ZIP CODE:			
STATE LICENS	E NUMBER: 24591501							
(X4) ID PREFIX TAG	MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE	
S 0000	This report is the result of a relicensure survey conducted onsite on April 18, 2023, at St. Luke's Anderson Ambulatory Surgery Center. It was determined that the facility was not in compliance with the requirements of the Pennsylvania Department of Health's Rules and Regulations for Ambulatory Care Facilities, Annex A, Title 28, Part IV, Subparts A and F, Chapters 551-573, November			S 0000				
S 033A	033A							
LABORATORY I	DIRECTOR'S OR PROVIDER/SUPPLI	ER REPRESENTATIVE'S SIGN	ATURE		TITLE:	(X6) DATE:		

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
		390326			<u></u>	04/18/2023	
NAME OF PROVIDER OR SUPPLIER: ST. LUKE'S ANDERSON AMBULATORY SURGERY CENTER STATE LICENSE NUMBER: 24591501			STREET ADDRESS, 2200 ST. LUK EASTON, PA	E'S BLVD	XIP CODE:		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DE PREFIX MUST BE PRECEEDED BY FULL REGULATORY O IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE	
S 033A	Continued from page 1 553.3 (1) Governing Body I 553.3 Governing Body respo (1) Conforming to local laws. This REGULATION is not	nsibilities include: o all applicable Federal,	State, and	S 033A	The Administrator, Director Nursing and the Patient Safe Officer were educated that investigation reports and actitaken to promote patient safe be submitted quarterly to the safety committee. The Patient Safety Officer were sponsible for providing investigation reports and the taken to promote patient safety committee meeting at Ander ASC. The Administrator will responsible for ensuring the investigation reports, including actions taken, are reflected in patient safety committee meeting at Ander Administrator will be responsible for ensuring the investigation reports, including actions taken, are reflected in patient safety committee meeting at Administrator will be responsible plan of correction. Annual Administrator will be responsible providing a report to the boar regarding patient safety even investigations at the Anderson Ambulatory Surgery Center.	ions ety must patient ill be actions ety son be ng the eting sible for ally, the sible for rd ats and on	Completion Date: 06/30/2023 Status: APPROVED Date: 05/30/2023

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
	390326				<u></u>	04/18/2023		
NAME OF PROVIDER OR SUPPLIER: ST. LUKE'S ANDERSON AMBULATORY SURGERY CENTER			STREET ADDRESS, 2200 ST. LUK EASTON, PA	E'S BLVD	IP CODE:			
	E NUMBER: 24591501			1				
(X4) ID PREFIX TAG	MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE DD BY FULL REGULATORY O FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SE CROSS-REFERENCED TO THE	IOULD BE	(X5) COMPLETE DATE	
S 033A	Based on review of factinterview (EMP), it was to conform to applicable. St. Luke's Anderson And was not in compliance. Act 13 of 2002 Medical Reduction of Error (Modern Patient Safety Section A patient safety officer all of the following (committee regarding and patient safety as a result commenced pursuant to the safety and the safety are safety as a result commenced pursuant to the safety officer failed to safety of safety	s determined the factors are state laws. In the state laws. In t	Center State Law: and r 3. ty officer. y shall do ient safety comote	S 033A				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00		(X3) DATE SURVEY COMPLETED:	
	390326					04/18/2023	
NAME OF PROVIDER OR SUPPLIER: ST. LUKE'S ANDERSON AMBULATORY SURGERY CENTER STATE LICENSE NUMBER: 24591501			STREET ADDRESS, 2200 ST. LUK EASTON, PA	E'S BLVD	IIP CODE:		
STATE LICENS (X4) ID		OF DEFICIENCIES (EACH DE	FICIENCY	ID	PROVIDER'S PLAN OF CORRE	CTION (EACH	(X5)
PREFIX TAG		D BY FULL REGULATORY OF FYING INFORMATION)	R LSC	PREFIX TAG	CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	COMPLETE DATE
S 033A	Continued from page 3			S 033A			
	committee actions take	n to promote patient	t safety,				
	as a result of the patien	t safety officer's					
	investigations.						
	Findings include:						
	Review on April 18, 20)23. of facility docu	ment "St.				
	Luke's Patient Safety P	-					
	Ambulatory Surgery C						
	2022, revealed "The Pa						
	do all of the following:	1.Serve on the Patie	ent Safety				
	Committee 2.Ensure th	e investigation of al	l reports				
	of serious events and ir	ncidents 3.Take such	n action				
	as is immediately neces	ssary to ensure patie	ent safety				
	as a result of any inves						
	Patient Safety Commit						
	to promote patient safe	-	•				
	commenced per items	."					
	Review on April 18, 2023, of the facility's "I		"Patient				
	Safety Committee" med	•					
	17, 2022, revealed "P	•					
	Aggregate event data for		_				
	reviewed. Incident tota	l:14, Infrastructure l	Failures				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:	
	390326				_00	04/18/2023	
NAME OF PROVIDER OR SUPPLIER: ST. LUKE'S ANDERSON AMBULATORY SURGERY CENTER STATE LICENSE NUMBER: 24591501			STREET ADDRESS, 2200 ST. LUK EASTON, PA	E'S BLVD	IIP CODE:		
(X4) ID		OF DEFICIENCIES (EACH DE	FICIENCY	ID	PROVIDER'S PLAN OF CORRE	CTION (EACH	(X5)
PREFIX TAG	MUST BE PRECEEDE	ED BY FULL REGULATORY O FYING INFORMATION)		PREFIX TAG	CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	COMPLETE DATE
S 033A	Continued from page 4			S 033A			
	total: 3 reviewed" C	Continued review rev	ealed no				
	documentation the pati	ent safety officer su	bmitted				
	investigation reports to	the patient safety co	ommittee.				
	Review on April 18, 20	023, of the facility's	"Patient				
	Safety Committee" me	•	-				
	23, 2023, revealed "]	-					
	Report, Aggregate ever						
	reviewed. Incident tota						
	total:0 reviewed, 2 Tra	•					
	Continued review reve						
	patient safety officer su	_	on reports				
	to the patient safety con	mmittee.					
	Interview on April 18,	2023 with EMP2 at	+				
	approximately 1:30 PM						
	documentation the pati						
	investigation reports to	-					
	<i>5</i> - F- 60	1					
	Based on review of fac	eility documents and	staff				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00		(X3) DATE SURVEY COMPLETED:	
390326		390326			<u>ou</u>	04/18/2023	
NAME OF PROVIDER OR SUPPLIER: ST. LUKE'S ANDERSON AMBULATORY SURGERY CENTER STATE LICENSE NUMBER: 24591501			STREET ADDRESS, 2200 ST. LUK EASTON, PA	E'S BLVD	IP CODE:		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH D PREFIX MUST BE PRECEEDED BY FULL REGULATORY (TAG IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
S 033A	interview (EMP), it was to conform to applicab St. Luke's Anderson A was not in compliance Act 13 of 2002 Medica Reduction of Error (Medical Facility Safety Section A patient Safety Section A patient safety officer all of the following (all reports of serious evaluations of the safety con Responsibilities A particular facility shall define Receive reports from the pursuant to section 309. This is not met as evident Based on review of facility in the safety con the pursuant to section 309.	mbulatory Surgery C with the following S al Care Availability a CARE) Act, Chapter on 309. Patient safety of a medical facility (2) Ensure the invest vents and incidents mittee (b) atient safety commit o all of the following the patient safety office. (2)"	Center State Law: and r 3. y officer. y shall do tigation of Section tee of a g: (1) teer	S 033A			

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■ *		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
		390326		B. WING:		04/18/2023	
NAME OF PROVIDER OR SUPPLIER: ST. LUKE'S ANDERSON AMBULATORY SURGERY CENTER STATE LICENSE NUMBER: 24591501			STREET ADDRESS, 2200 ST. LUK EASTON, PA	E'S BLVD	IP CODE:		
(X4) ID		OF DEFICIENCIES (EACH DE	FICIENCY	ID	PROVIDER'S PLAN OF CORRE	CTION (EACH	(X5)
PREFIX TAG	MUST BE PRECEEDE IDENTII	ED BY FULL REGULATORY OF FYING INFORMATION)		PREFIX TAG	CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	COMPLETE DATE
S 033A	Continued from page 6			S 033A			
	safety committee failed patient safety officer to reports.	-					
	Findings include: Review on April 18, 2023, of facility document "St, Luke's Patient Safety Plan, St. Luke's Anderson Ambulatory Surgery Center" reviewed December 2022, revealed " The Patient Safety Committee shall do all of the following: 1. Receive reports from the Patient Safety Officer(s) Evaluate investigations and action of the Patient Safety Officer(s) on all reports"						
Review on April 18, 2023, of the facility's "Patient Safety Committee" meeting minutes dated October 17, 2022, revealed there was a total of 17 safety events reported. Continued review revealed no documentation the committee reviewed patient safety investigation reports submitted by the patient safety officer.							

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		* /	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:	
	390326				00	04/18/2023	
NAME OF PROVIDER OR SUPPLIER: ST. LUKE'S ANDERSON AMBULATORY SURGERY CENTER STATE LICENSE NUMBER: 24591501			STREET ADDRESS, 2200 ST. LUK EASTON, PA	E'S BLVD	ZIP CODE:		
STATE LICENS (X4) ID		OF DEFICIENCIES (EACH DE	FICIENCY	ID	PROVIDER'S PLAN OF CORRE	CTION (FACH	(X5)
PREFIX TAG	MUST BE PRECEED!	ED BY FULL REGULATORY O FYING INFORMATION)		PREFIX TAG	CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	COMPLETE DATE
S 033A	Continued from page 7			S 033A			
	Review on April 18, 20 Safety Committee" me 2023, revealed there w reported. Continued re documentation the con safety investigation rep safety officer. Interview on April 18, approximately 1:30 PM minutes provided no do of safety event reports the patient safety comm	eeting minutes dated as a total of 18 safet view revealed no mittee reviewed parorts submitted by the 2023, with EMP2 and confirmed the meaning was submitted for revealed as a total of the safety of	January ey events tient ne patient t eting evestigation				

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Pennsylvania Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
		390326				04/18/2023	
NAME OF PROVIDER OR SUPPLIER: ST. LUKE'S ANDERSON AMBULATORY SURGERY CENTER			STREET ADDRESS, 2200 ST. LUK EASTON, PA	E'S BLVD	IIP CODE:		
STATE LICENS (X4) ID	E NUMBER: 24591501 SUMMARY STATEMENT	OF DEFICIENCIES (EACH DE	FICIENCY	ID	PROVIDER'S PLAN OF CORREC	CTION (EACH	(X5)
PREFIX TAG	MUST BE PRECEEDE	ED BY FULL REGULATORY OF FYING INFORMATION)		PREFIX TAG	CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	COMPLETE DATE
S 312Q				S 312Q			

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			(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:	
		390326			00	04/18/2023	
ST. LUKE CENTER STATE LICENS (X4) ID PREFIX	MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O		E'S BLVD	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO	OULD BE	(X5) COMPLETE
TAG		FYING INFORMATION)			CROSS-REFERENCED TO THE A	APPROPRIATE	DATE
S 312Q	patient's bill of rights:	he minimal provisions for the minimal provisions for general and a particle of the motified. The ed shall be notified prior	tient is	S 312Q	The Medical Director of the be responsible to educate all providers that when an emeroccurs and a patient must be transferred to another facility receiving facility must be no the transfer. The Medical Director of the ASC will also educate all providers that they must doc this notification in the patient electronic medical record. The Administrator of the ASC with e "Transfer from ASU/PAC to Hospital" policy that the frequired to contact the receive facility of an emergent transfer. The Director of Nursing or divil be responsible for perform audits of electronic medical for all transfers from the And ASC to ensure there is documentation that the receive facility was notified of the transfers audits will be reviewed the Administrator of the ASC will be reviewed at the quart Quality/PI committee meeting.	gency y, the tified of rector of l ument tt's he iill add to CU/OR facility is ying fer. designee rming records erson ving ansfer. d with C and erly	Completion Date: 06/30/2023 Status: APPROVED Date: 05/30/2023

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Pennsylvania Department of Health

	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER 390326		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00 B. WING:		(X3) DATE SURVEY COMPLETED: 04/18/2023	
NAME OF PROVIDER OR SUPPLIER: ST. LUKE'S ANDERSON AMBULATORY SURGERY CENTER STATE LICENSE NUMBER: 24591501			STREET ADDRESS, 2200 ST. LUK EASTON, PA	E'S BLVD	IIP CODE:		
(X4) ID PREFIX TAG				ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
S 312Q	Continued from page 10			S 312Q	The Administrator of the AS responsible for the plan of co and will review audit results quarterly Quality/PI committ meeting. Additionally, the Administrator will be respon providing a report to the boar regarding annually regarding safety events and investigation the Anderson Ambulatory Succenter.	orrection at the tee sible for rd g patient ons at	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:	
	390326				_00	04/18/2023	
NAME OF PROVIDER OR SUPPLIER: ST. LUKE'S ANDERSON AMBULATORY SURGERY CENTER STATE LICENSE NUMBER: 24591501			STREET ADDRESS, 2200 ST. LUK EASTON, PA	E'S BLVD	ZIP CODE:		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH D		FICIENCY	ID	PROVIDER'S PLAN OF CORRE	CTION (EACH	(X5)	
PREFIX TAG	MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	COMPLETE DATE
S 312Q	Continued from page 11 Based on review of fac	sility documents, ma	dical	S 312Q			
	records (MR), and inte						
	was determined the fac	*	, , , , , , , , , , , , , , , , , , ,				
	receiving facility that a						
	transferred in four of fo	-					
	(MR3, MR4, MR5 and		icviewed.				
	Findings include:						
	Review on April 18, 20	023 of facility policy	Ι,				
	"Transfer from ASU/P.	ACU/OR to Hospita	l," last				
	reviewed December 20	22, revealed no					
	documentation the faci	lity was required to	contact				
	the receiving facility of	f an emergent transf	er.				
	Review of MR3 on Ap	oril 18, 2023, reveale	d the				
	patient in MR3 present	ted to surgery center	on				
	January 23, 2023, and experienced complications		cations				
	related to surgical proc	edure. Further revie	ew of				
	MR3 revealed the patie	-					
	higher level of care. C						
	there was no document	tation in MR3 the re-	ceiving				

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STATEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER/PLAN OF CORRECTION (POC) IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVE COMPLETED:	ΞΥ	
	390326			A. BLDG: _ B. WING: _		04/18/2023	
NAME OF PROVIDER OR SUPPLIER: ST. LUKE'S ANDERSON AMBULATORY SURGERY CENTER STATE LICENSE NUMBER: 24591501		TORY SURGERY	STREET ADDRESS, 2200 ST. LUK EASTON, PA	E'S BLVD	IP CODE:		
	ATEMENT	T OF DEFICIENCIES (EACH DE	EFICIENCY	ID	PROVIDER'S PLAN OF CORRE	CTION (FACH	(X5)
	PRECEED	ED BY FULL REGULATORY O IFYING INFORMATION)		PREFIX TAG	CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	COMPLETE DATE
S 312Q Continued from pa	ge 12			S 312Q			
facility was not Review of MRA patient in MR4 December 20, 2 complications review of MR4 transfer to high revealed there receiving facilitransfer. Review of MR5 4, 2023, and ex surgical proced revealed the palevel of care. On documentation of the many surgical proced revealed of an in Review of MR6 Review of	on Appresent of the continuous	fan incoming patient oril 18, 2023, revealed to surgery centered to surgical procedure of the patient required of care. Continued documentation in Monotified of an incomposition of the surgery centered complications related to surgery centered complications related to review revealed to the receiving far grapher transfer.	ed the on e. Further ed a review R4 the ing Pateint ed the on April lated to 5 higher here was cility was				

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER				(X3) DATE SURVEY COMPLETED:	
		390326			00.	04/18/2023	
NAME OF PROVIDER OR SUPPLIER: ST. LUKE'S ANDERSON AMBULATORY SURGERY CENTER STATE LICENSE NUMBER: 24591501			STREET ADDRESS, 2200 ST. LUK EASTON, PA	E'S BLVD	XIP CODE:		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFIC PREFIX MUST BE PRECEEDED BY FULL REGULATORY OR L TAG IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
S 312Q	4, 2023, and experienced complications related to surgical procedure. Further review of MR6 revealed patient required a transfer to higher level of care. Continued review revealed there was no documentation in MR6 receiving facility was notified of incoming patent transfer. Interview with EMP1 at approximately 12:30 PM on April 18, 2023, confirmed the above medical records did not contain documentation the receiving facility was notified of incoming emergent patient transfers.		S 312Q				
S 573A				S 573A			

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER	I) PROVIDER/SUPPLIER/CLIA ENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:	
		390326			00	04/18/2023		
ST. LUKE' CENTER	VIDER OR SUPPLIER: S ANDERSON AMBULAT SE NUMBER: 24591501 SUMMARY STATEMENT	ORY SURGERY OF DEFICIENCIES (EACH DE	STREET ADDRESS, 2200 ST. LUK EASTON, PA	E'S BLVD	IP CODE: PROVIDER'S PLAN OF CORRE	CTION (FACH	(X5)	
PREFIX TAG				PREFIX TAG			COMPLETE DATE	
S 573A	Continued from page 14 557.3 (a) QA & Improveme 557.3 The Quality Assurance (a) The quality assurance monitoring and evaluation of defined criteria that reflect of experience and relate to the Sources of data include the reports, infection control records in the diagnosis and determine appropriate to the diagnosis patients shall segregate data. This REGULATION is not	nce program shall inclusted data collected, based of current knowledge and coare provided by the semedical records, incider cords and patient completain sufficient data to sufficient d	de on clinical rvice. nt aints. apport	S 573A	The Administrator and Direct Nursing will be educated that pediatric quality data must be segregated from adult quality which is reviewed at the ASQ Quality/PI committee meeting Quarterly, the Administrator ASC will present quality data ASC's Quality/PI Committee separating pediatric data from data. This data will be include the Quality/PI committee meminutes. The Administrator of the AST responsible for the plan of correction. Annually, the Administrator will be responsible for the boar regarding quality data review the ASC's Quality/PI Committee the	e y data C's ng. of the a at the e meeting, m adult ded in cetting C's will be asible for rd wed at ittee gregate	Completion Date: 06/30/2023 Status: APPROVED Date: 05/30/2023	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/CI IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:		
		390326				04/18/2023	
NAME OF PROVIDER OR SUPPLIER: ST. LUKE'S ANDERSON AMBULATORY SURGERY CENTER STATE LICENSE NUMBER: 24591501			STREET ADDRESS, 2200 ST. LUK EASTON, PA	E'S BLVD	MP CODE:		
(X4) ID		OF DEFICIENCIES (EACH DE	FICIENCY	ID	PROVIDER'S PLAN OF CORRE	CTION (FACH	(X5)
PREFIX TAG	MUST BE PRECEEDE IDENTII	ED BY FULL REGULATORY OF FYING INFORMATION)		PREFIX TAG	CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	COMPLETE DATE
S 573A	Continued from page 15			S 573A			
	Based on a review of fa	acility documents ar	nd				
	employee interview (E	*					
	faciliy failed to collect						
	patient data for their qu	uality assurance repo	orts.				
	Findings include:						
	Review on April 18, 20 Lukes Anderson Ambu (SLAASC), Infection O	latory Surgery Cent	ter				
	2023," revealed " The						
	ambulatory surgery cer		•				
	Specialty Pavilion (And						
	the adult and pediatric	• ,					
	Review on April 18, 20 minutes "PI Committee October 17, 2022, and the following quality m reported during the me (turn around time), 1st Rates, Pain audits. Fur	e" dated July 18, 202 January 23, 2023, reneasures were documeting: Debrief/Time Case Starts, Cancell	22, evealed nented as Out, TAT lation				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
		390326				04/18/2023	
ST. LUKE' CENTER	VIDER OR SUPPLIER: S ANDERSON AMBULAT SE NUMBER: 24591501	ORY SURGERY	STREET ADDRESS, 2200 ST. LUK EASTON, PA	E'S BLVD	IP CODE:		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DE PREFIX MUST BE PRECEEDED BY FULL REGULATORY O IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	(X5) COMPLETE DATE
S 573A	documentation pediatric quality data was reported or segregated from the reported data. Interview on April 18, 2023, at approximately 9:15 AM with EMP2 confirmed pediatric data was not segregated in the facility's quality data collection and reporting.			S 573A			
S 574A				S 574A			

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	STATEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER PLAN OF CORRECTION (POC) IDENTIFICATION NUMBI			(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:		
		390326			B. WING: 04/18/2023			
ST. LUKE' CENTER	VIDER OR SUPPLIER: S ANDERSON AMBULAT E NUMBER: 24591501	ORY SURGERY	STREET ADDRESS, 2200 ST. LUK EASTON, PA	E'S BLVD	IP CODE:			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DE PREFIX MUST BE PRECEEDED BY FULL REGULATORY O IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE		
S 574A	(1) A practitioner(2) A representati(3) A registered n	Improvement Committed consist of the following who is not an owner, we of administration, the urse, are personnel, as appropriate the committee of the committe	ee g:	S 574A	The Coordinator of Accredit and Standards will educate the Administrator of the ASC and Director of Nursing that the Plan must identify the requiremembers of the Quality Important Committee. Annually, the Administrator ASC and Director of Nursing review the list of members of Quality Improvement Commupdate the list as needed. Annually, the Administrator ASC will review the Quality list of required members with Coordinator of Accreditation Standards to ensure accuracy Additionally, the Administrate the ASC will be responsible providing a report to the boar regarding the members of the Improvement Committee of Anderson Ambulatory Surge Center on an annual basis.	he he hd the Quality red rovement of the g will f the hittee and of the Plan and h the h & y. http://doi.org/	Completion Date: 06/30/2023 Status: APPROVED Date: 05/31/2023	

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
			B. WING:		04/18/2023			
NAME OF PROVIDER OR SUPPLIER: ST. LUKE'S ANDERSON AMBULATORY SURGERY CENTER STATE LICENSE NUMBER: 24591501		ORY SURGERY	STREET ADDRESS, 2200 ST. LUK EASTON, PA	E'S BLVD	MP CODE:			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DE PREFIX MUST BE PRECEEDED BY FULL REGULATORY OF TAG IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE		
S 574A	Continued from page 18 Based on review of facility documents and interview with staff (EMP) it was determined the facility's quality plan failed to identify the required members for the Quality Improvement Committee. Findings Include: Review on April 18, 2023, of facility document "Quality Management/Improvement and Data Collection PI (performance improvement) Process Plan," dated June 1, 2021, revealed no documentation for the required members of the committee. Interview on April 18, 2023, at approximately 9:30 AM with EMP2 confirmed the Quality Improvement Plan did not state the required members for the		ment ata Process f the ely 9:30 provement	S 574A				
S 574C				S 574C				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER IDENTIFICATION NUMBE			(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00		(X3) DATE SURVEY COMPLETED:		
		390326				04/18/2023	
ST. LUKE CENTER	VIDER OR SUPPLIER: 'S ANDERSON AMBULAT SE NUMBER: 24591501	ORY SURGERY	STREET ADDRESS, 2200 ST. LUK EASTON, PA	E'S BLVD	IIP CODE:		
(X4) ID PREFIX TAG	IX MUST BE PRECEEDED BY FULL REGULATORY (G IDENTIFYING INFORMATION)			ID PREFIX TAG			(X5) COMPLETE DATE
S 574C	(1) Reports made (2) Minutes of contime, persons, attending, des reviewed and recommendation	of the activities shall into the governing body, mmittee meetings included in the scription and results of coions made by the committee including appendication programs need heare uncovered as a resum.	clude: ling date, cases ittee, propriate essary	S 574C	The Administrator and Direct Nursing will be educated that Quality/PI committee meeting minutes must include the post causes and problem resolution any deficits identified in the measures that were reviewed Quarterly, the Director of Nordesignee will submit Quality minutes including problem resolution for any deficits id to the Administrator of the AST responsible for the plan of correction. Annually, the Administrator will be responsible for the boar regarding quality data measure problem resolution for any didentified during the ASC's Quality/PI Committee meeting	at the ang tential on for quality d. arsing or a meeting entified ASC. GC will be asible for ard ares and deficits	Completion Date: 06/30/2023 Status: APPROVED Date: 05/30/2023

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STATEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER/C PLAN OF CORRECTION (POC) IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:	
	390326				04/18/2023	
NAME OF PROVIDER OR SUPPLIER: ST. LUKE'S ANDERSON AMBULA' CENTER STATE LICENSE NUMBER: 24591501	TORY SURGERY	STREET ADDRESS, 2200 ST. LUK EASTON, PA	E'S BLVD	XIP CODE:		
	T OF DEFICIENCIES (EACH DE	FICIENCY	ID	PROVIDER'S PLAN OF CORRE	CTION (EACH	(X5)
PREFIX MUST BE PRECEED	DED BY FULL REGULATORY O		PREFIX TAG	CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	COMPLETE DATE
S 574C Continued from page 20			S 574C			
Based on review of fa	cility documents and	interview				
with staff (EMP), it w	vas determined the qu	uality				
improvement meeting	minutes failed to do	cument				
recommendations and						
measures reviewed for		•				
reviewed. (Q3 2022, 0	Q4 2022 and Q1 2023	3)				
Findings include:						
Review on April 18, 2	2023, of facility docu	ment				
"Quality Management	t/Improvement and D	ata				
Collection PI (perforn	nance improvement)	Process				
Plan", dated June 1, 20	021, revealed " Dat	ta is				
collected and analyzed	d from event reports,					
retrospective chart rev	view, nursing audit ar	nd direct				
observation. If deficit	ts are identified, pote	ntial				
causes and problem re						
Corrective action is re						
than the identified me	asurable performance	e goal"				
Davious on Amril 10	0022 of the "DI Com	mittaa"				
Review on April 18, 2 meeting minutes for Q	•					
incernig influtes for Q	(5 2022, V 7 2022 an	u V 1				

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	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/G IDENTIFICATION NUMBER			IPLE CONSTRUCTION:	(X3) DATE SURVE COMPLETED:		
		390326			00	04/18/2023		
ST. LUKE' CENTER	VIDER OR SUPPLIER: S ANDERSON AMBULAT	FORY SURGERY	STREET ADDRESS, 2200 ST. LUK EASTON, PA	E'S BLVD	ZIP CODE:			
(X4) ID	SE NUMBER: 24591501	OF DEFICIENCIES (FACH DE	SEICIENCY	ID	PROMIDERIC BY AN OF CORRE	CTION (FACIL	(X5)	
PREFIX TAG	PREFIX MUST BE PRECEEDED BY FULL REGULATORY OR LSC			PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	COMPLETE DATE	
S 574C	Continued from page 21			S 574C				
	2023, revealed the following quality measures were documented as reviewed at the meeting and did not meet established compliance rates: TAT (turn around time), 1st Case Starts, Cancellation Rates, Pain audits. Further review revealed no documentation of potential causes and problem resolution. Interview on April 18, 2023, at approximately 9:30 AM with EMP2 confirmed recommendations and corrective actions were not documented in the meeting minutes for quality measures that did not meet compliance rates.							
S 6747				S 6747				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER IDENTIFICATION NUMBE			(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00		(X3) DATE SURVEY COMPLETED:		
		390326				04/18/2023	
ST. LUKE' CENTER	VIDER OR SUPPLIER: S ANDERSON AMBULAT SE NUMBER: 24591501	ORY SURGERY	STREET ADDRESS, 2200 ST. LUK EASTON, PA	E'S BLVD	IP CODE:		
(X4) ID	T	OF DEFICIENCIES (EACH DE	FICIENCY	ID	PROVIDER'S PLAN OF CORREC	CTION (EACH	(X5)
PREFIX TAG	IX MUST BE PRECEEDED BY FULL REGULATORY OR LSC		R LSC	PREFIX TAG	CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	COMPLETE DATE
S 6747	Continued from page 22			S 6747			
	The ventilation system shall in accordance with the writt ensure that a properly condiminimum filtration, humidit is provided in critical areas recovery suites under Chapter 571 (relating to cort.) This REGULATION is not	tioned air supply meetir ty and temperature requi such as the surgical and estruction standards).	e to ng irements		All of the monitoring of temperature and humidity at the Anderson will be the responsibility of the engineering department around clock, including weekends. The Engineering Department will responsible for notifying the when temperature and/or humidity and the monitoring of Temperature Humidity" policy will be chareflect this process by the Administrator of the ASC. Quarterly, temperature and he data will be presented by the director to the Administrator Infection Preventionist and reat the ASC's Infection Control Committee meeting. The Administrator will be responsible for the plan of cound will review temperature humidity report data quarterly Annually, the Administrator responsible for providing a rethe board regarding temperate humidity data.	n ASC the nd the The I be ASC midity current and inged to numidity facility and eviewed ol orrection and y. will be eport to	Completion Date: 06/30/2023 Status: APPROVED Date: 05/30/2023

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:	
		390326			00	04/18/2023	
ST. LUKE' CENTER	VIDER OR SUPPLIER: S ANDERSON AMBULAT E NUMBER: 24591501	ORY SURGERY	STREET ADDRESS, 2200 ST. LUK EASTON, PA	E'S BLVD	IIP CODE:		
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
S 6747	Based on review of fact with facility staff (EMI facility failed to ensure temperature requirements. Tindings include: Review on April 18, 20 "Monitoring of Temperature and logging in the Operating Room attempt to minimize the the potential for bacter humidity shall ordinari and 60%. The temperature Room/Procedure Room range of 68° to 73° F. If acceptable range will be Department "	P), it was determined the ventilation systems. D23, of the facility perature and Humidity enter" reviewed Decablish protocol for the gof temperature and /Procedure Rooms is estatic electricity arial growth Relatively be maintained between the Copins will be maintained Deviations from the pereported to the Enterpress of the venture of of the ven	olicy olicy on the ember ne daily humidity n an nd reduce we tween 30% berating d at a gineering	S 6747			
	1.Review on April 16,	2023, or facility doc	Juillelit				

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I '		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
390326			B. WING:		04/18/2023		
NAME OF PROVIDER OR SUPPLIER: ST. LUKE'S ANDERSON AMBULATORY SURGERY CENTER STATE LICENSE NUMBER: 24591501			STREET ADDRESS, CITY, STATE, ZIP CODE: 2200 ST. LUKE'S BLVD EASTON, PA 18045				
(X4) ID		OF DEFICIENCIES (EACH DE	FICIENCY	ID	PROVIDER'S PLAN OF CORREC	CTION (EACH	(X5)
PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFI MUST BE PRECEEDED BY FULL REGULATORY OR IDENTIFYING INFORMATION)			PREFIX TAG	CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETE DATE
S 6747	Continued from page 24			S 6747			
	"St. Luke's Anderson A	` .					
	room)/Humidity" recor						
	OR1 room temperatures were recorded as below						
	the required room temperatures on March 8 and 9 and OR4 room temperatures were recorded as below the required temperatures on the 1, 2, 3, 6,						
	7, 8, 9, 16, 17, 20, 21, 2	her					
	review revealed no doc	itures					
	were recorded for OR1, OR4, OR5, OR6 on						
	March 4, 5, 11, 12, 18, 19, 25 and 26. Continued						
	review revealed no documentation deviations were						
	reported to the engineering department.						
	2.Review on April 18,	cument					
	"St. Luke's Anderson A						
	room)/Humidity" recor						
	OR1 room temperature						
	required room tempera		· ·				
	OR4 room temperature the required temperature						
	14, 17, and 18, and OF						
	recorded below the req	-					
	7 and 18. Further review		ı				

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NAME OF PROVIDER OR SUPPLIER: ST. LUKE'S ANDERSON AMBULATORY SURGERY CENTER STATE LICENSE NUMBER: 24591501 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY PREFIX MUST BE PRECEEDED BY FULL REGULATORY OR LSC B. WING:	, ,		(XI) PROVIDER/SUPPLIER/OIDENTIFICATION NUMBER	(I) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:	
ST. LUKE'S ANDERSON AMBULATORY SURGERY CENTER STATE LICENSE NUMBER: 24591501 (M) ID PREFIX TAG WILST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) S 6747 Continued from page 25 S 6747 Continued review revealed no documentation deviations were reported to the engineering department. 3. Review on April 18, 2023, of facility document "Temperature and Humidity Monitoring Record, SPD & Prep Pack, Temperature: 68° to 73°, Humidity 30% and 60%" revealed room temperatures for the sterile processing area and surgical instrument packing area were recorded as below the required temperatures on March 6, 9, 13, 14, 15, 16, 20, 21, and 29. Further review revealed no documentation the engineering department deviations were reported to documentation temperatures on March 6, 12, 11, 12, 18, 19, 25 and 26. Continued review revealed no documention the engineering department deviations were reported to	390326			A. BLDG:00 B. WING:		04/18/2023			
Summary Statement of Deficiencies (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC COMPRIST TAG DESTRIPTING INFORMATION) PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DATE OF THE APPROPRIATE	ST. LUKE'S ANDERSON AMBULATORY SURGERY CENTER			2200 ST. LUK	E'S BLVD	MP CODE:			
PREFIX TAG MUST BE PRECEDIDED BY FULL REQULATORY OR LSC IDENTIFYING INFORMATION) S 6747 Continued from page 25 documentation temperatures were recorded for OR1, OR4, OR5, OR6 on April 1, 2, 8, 9, 15, and 16. Continued review revealed no documentation deviations were reported to the engineering department. 3.Review on April 18, 2023, of facility document "Temperature and Humidity Monitoring Record, SPD & Prep Pack, Temperature: 68° to 73°, Humidity 30% and 60%" revealed room temperatures for the sterile processing area and surgical instrument packing area were recorded as below the required temperatures on March 6, 9, 13, 14, 15, 16, 20, 21, and 29. Further review revealed no documentation temperatures were recorded on March 1, 2, 11, 12, 18, 19, 25 and 26. Continued review revealed no documention the engineering department deviations were reported to	<u> </u>		OF DEFICIENCIES (EACH DE	FICIENCY	ID	DROVIDEDIC DI ANI OF CORDE	CTION (FACU	(Y5)	
documentation temperatures were recorded for OR1, OR4, OR5, OR6 on April 1, 2, 8, 9, 15, and 16. Continued review revealed no documentation deviations were reported to the engineering department. 3.Review on April 18, 2023, of facility document "Temperature and Humidity Monitoring Record, SPD & Prep Pack, Temperature: 68° to 73°, Humidity 30% and 60%" revealed room temperatures for the sterile processing area and surgical instrument packing area were recorded as below the required temperatures on March 6, 9, 13, 14, 15, 16, 20, 21, and 29. Further review revealed no documentation temperatures were recorded on March 1, 2, 11, 12, 18, 19, 25 and 26. Continued review revealed no documention the engineering department deviations were reported to	PREFIX	MUST BE PRECEEDED BY FULL REGULATORY O				CORRECTIVE ACTION SH	OULD BE	COMPLETE DATE	
OR1, OR4, OR5, OR6 on April 1, 2, 8, 9, 15, and 16. Continued review revealed no documentation deviations were reported to the engineering department. 3.Review on April 18, 2023, of facility document "Temperature and Humidity Monitoring Record, SPD & Prep Pack, Temperature: 68° to 73°, Humidity 30% and 60%" revealed room temperatures for the sterile processing area and surgical instrument packing area were recorded as below the required temperatures on March 6, 9, 13, 14, 15, 16, 20, 21, and 29. Further review revealed no documentation temperatures were recorded on March 1, 2, 11, 12, 18, 19, 25 and 26. Continued review revealed no documention the engineering department deviations were reported to	S 6747	Continued from page 25			S 6747				
4.Review on April 18, 2023, of facility document "Temperature and Humidity Monitoring Record, SPD & Prep Pack, Temperature: 68° to 73°,		documentation temperatures were recorded for OR1, OR4, OR5, OR6 on April 1, 2, 8, 9, 15, and 16. Continued review revealed no documentation deviations were reported to the engineering department. 3.Review on April 18, 2023, of facility document "Temperature and Humidity Monitoring Record, SPD & Prep Pack, Temperature: 68° to 73°, Humidity 30% and 60%" revealed room temperatures for the sterile processing area and surgical instrument packing area were recorded as below the required temperatures on March 6, 9, 13, 14, 15, 16, 20, 21, and 29. Further review revealed no documentation temperatures were recorded on March 1, 2, 11, 12, 18, 19, 25 and 26. Continued review revealed no documention the engineering department deviations were reported to the engineering department. 4.Review on April 18, 2023, of facility document		toument ecord, or and orded as 6, 9, 13, were and ention the ported to cument ecord,					

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PLAN OF CORRECTION (POC) IDENT		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 390326		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00 B. WING:		(X3) DATE SURVEY COMPLETED: 04/18/2023	
NAME OF PROVIDER OR SUPPLIER: ST. LUKE'S ANDERSON AMBULATORY SURGERY CENTER			STREET ADDRESS, 2200 ST. LUK EASTON, PA	E'S BLVD	ZIP CODE:		
STATE LICENS (X4) ID PREFIX TAG	E NUMBER: 24591501 SUMMARY STATEMENT MUST BE PRECEEDI IDENTI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	(X5) COMPLETE DATE		
S 6747	Humidity 30% and 60%" revealed no documentation room temperatures for the sterile processing area and surgical instrument packing area were recorded on March 1, 2, 11, 12, 18, 19, 25 and 26. 5. Review on April 18, 2023, of facility document "Temperature and Humidity Monitoring Record, SPD Decontamination, Temperature: 60° to 73°, Humidity N/A" revealed no documentation room temperatures for the decontamination area were recorded on March 1, 2, 11, 12, 18, 19, 25, 26 and April 1, 2, 8, 9, 15, and 16. Interview on April 18, 2023, at approximately 11:30 AM, EMP2 confirmed the above temperature documentation and confirmed there was no documentation the engineering department was notified of deviations in the temperatures.		cking area 9, 25 cument ecord, o 73°, n room were 26 tely nperature	S 6747			

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Certified End Page

ST. LUKE'S ANDERSON AMBULATORY SURGERY CENTER

STATE LICENSE NUMBER: 24591501 SURVEY EXIT DATE: 04/18/2023

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeane Parisi

Deputy Secretary for Quality Assurance

fearre Janie

Debra L. Bogu MD

Debra L. Bogen, MD, FAAP Acting Secretary of Health



THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY